Best Practice in Wisconsin
Long-Term Care Support Network

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In many states, care management provides the foundation for long-term support services to frail, chronically ill and disabled individuals in the community.

As debate over the cost effectiveness of care management continues, questions about the nature of care management and the determinants of quality have gone largely un-addressed. Despite the considerable research on service use in long-term support systems and relationship of care management to likelihood of remaining in the community, and to the continuation of family care giving, there is little known about the nature of care management or distinctions in the quality of practice.

The literature on care management in community-based long-term care systems specifies a consistent set of core activities that are assumed to comprise the work of care management. There is general agreement on what these activities are, including:

- Needs Assessment, both initial and ongoing
- Gaining/Maintaining Access
- Cost Containment
- Advocacy
- Personalizing Care

How a care manager goes about these activities and what distinguishes levels of quality has not been the subject of research. For example, personalizing care is frequently cited as an important element of care management. There is, however, little clarity on what it means to personalize care, how one goes about it, and what it is about care that should be personalized.

Similar observations could be made about each of the care management activities identified above. Further adding to the lack of understanding about care management practice is its isolated nature. Care management is generally carried out by individual care managers working alone, providing little opportunity to view the work of colleagues. While care managers may be able to comment on the

outcomes achieved by colleagues, they are generally unable to describe, in any detail, how other care managers work. The work is largely invisible.

Lacking a clear understanding of the nature of the work, it is impossible to distinguish among various levels of quality, e.g. how excellence would be distinguished from adequate or unacceptable care management. Further, when outcomes are achieved, it is difficult to determine the processes that led to their achievement. It is also not clear whether or how a care manager's training, experience, philosophy or perspective influences the nature or quality of the work.

In an effort to gain a greater understanding of what care management is, how it is done and how to distinguish levels of quality, a study was designed to examine the practices of care managers identified as 'excellent' and to compare their practices to those of other care managers. The study was designed to allow the researchers to discover the characteristics of excellent care management practice rather than to define excellence or specify its attributes prior to the study. Consequently, a research method was selected that would allow 'excellent' care managers themselves to take the lead in describing the work, identifying its attributes, and specifying desirable outcomes. The goal of the study was to gain insight into care management practice from the perspectives of care managers who were considered to be excellent.

Subject Selection

The obvious challenge to conducting such a study is the identification of excellent care managers. Without predetermined criteria, there would be nothing to guide selection of care managers for inclusion in the study. At the same time, having predetermined criteria would force the researchers to define excellence, perhaps actively limiting subjects based on the researchers' limited perspective. Consulting any single source, either agency or individual, to identify excellent care managers could have the same effect e.g. privileging one perspective while excluding others.

To deal with this problem, subjects were selected by soliciting the names of the ‘best’ care managers in the Wisconsin long-term support system from multiple sources. Only those care managers whose name appeared on every list were included. The organizations consulted for lists of ‘the best’ care managers included: The Wisconsin Division of Community Services, The Management Group (a contract organization that conducts quality reviews of county care management programs), three consumer advocacy groups, an evaluator in the Wisconsin Bureau of Quality Compliance, and two staff from the Wisconsin Division of Health charged with oversight of long-term support programs in the state. While there may be other ways to define excellent care management practice, the subjects selected were believed to reflect most of the qualities perceived to reflect excellent practice.

Each individual or group was asked to submit the best care managers, in their opinions, working in the long-term support network. Consistent with the discovery purpose of the study, criteria for selection were not provided. However, after submitting the lists, the list makers were asked for criteria used to select care managers.

The names of six care managers appeared on each of the lists. Following human subjects’ approval, the six care managers were contacted and invited to participate in the study. After explaining the consent procedure and the purpose of the study, each of the care managers agreed to participate.

Characteristics of 'Best' CMs (regulators without CM experience)	Characteristics of 'Best' CMs (regulators/former CMs)	Best CM's Perceptions of Best CMs
Personal Attributes • Intelligent, efficient • Patient, kind, understanding **General Approach** • Advocate • Provides needed information to clients and providers • Respectful of client choices • Helps client define goals • Well organized • Able to deny inappropriate services • Welcomes advice from supervisor **Work Strategies** • Clearly lays out possibilities for clients • Assesses potential to meet goals • Follows through • Actively seeks advice from supervisor • Thorough assessment **Characteristics of Work** • Plan clear, clearly related to assessment • Clearly stated goals • Follow-through clearly documented • Paper plan that a new CM could walk into easily.	**Personal Attributes** • Like the people they work with • Genuinely caring • Kind, compassionate, respectful (not just of choice) • Attentive • Creative/Imaginative • Sense of humor • Knowledgeable about human nature • Responsive (interpersonally) **General Approach** • Lots of contact with clients • Advocate, access, maximize • Effective communication (not necessarily non-offensive) • Explores, discovers, creates new options • Goes above and beyond • Not too disorganized **Work Strategies** • Go out of their way to learn about the lives of clients • Continues to learn, takes initiative • Understands rules	**Personal Attributes** • Risk taker • Great listener • Creative • Uses sense of humor • Committed • Caring • Enjoys work • Has a meaningful life outside of work **General Approach** • Nurture the personal side of relationships • Manage without formulas • Emphatic, non-judgmental, respectful • Strategic **Work Strategies** • Able to delegate power • Understands the spirit of the rules • Advocates • Honors tacit understandings with supervisor

DATA COLLECTION

Data collection began by interviewing the six 'best' care managers to learn, to hear in their voices, with their words, and from their perspectives, what excellent care management looked like and how it was done. We approached this by simply asking each of these care managers to talk about their work. The questions were extremely open, so that the care managers could direct the interview as much as possible. We did not want to provide criteria, standards or expectations to which they could respond. Instead, we wanted the care managers to guide us to the criteria that characterized their practices.

After each interview, a team of researchers read carefully through the interview transcript, listened to the tape recording of the interview and identified patterns in how care managers thought about their work, how they thought about their clients, what their priorities were, how they related to colleagues and other providers, what they believed was most important to their success, and what they had learned along the way. We listened to how they allocated their time, how they solved conflicts in the work place, how they dealt with scarce resources, and how they talked about their work, their clients, and their coworkers.

Most of the original six expressed surprise at being identified as one of the best. They quickly pointed out other care managers they knew whose practices they considered excellent. They said many of these had been their own teachers and mentors. Five of the six expressed how difficult it was for them to talk about what they did and how they did it. This response was consistent with what other researchers have discovered about invisible work, particularly related to care giving. Not only is this kind of work invisible to others, it is often invisible to the caregivers themselves. In fact, none of these care managers identified a formula, a system or a plan that guided their work.

In order to distinguish what was different about these six care managers, it was necessary to find a comparison group. We therefore requested a list of care managers who were considered by our sources to be 'very good,' and a third list who 'got the work done' or were 'good enough' or 'new to the work,' i.e., just learning it. We interviewed ten care managers from each of these additional lists.

These interviews were also taped, transcribed and reviewed by the research team. Similar questions were used to interview the care managers included in these other groups. Common patterns and themes were identified for each of these groups and the

characteristics that distinguished them from each other were identified. This comparative analysis allowed the researchers to identify what was unique about the 'excellent' group. This will be the focus of the discussion.

Among the three groups of care managers involved in this study, differences focused around the following issues: the perceptions of the role of care managers' supervisors, the meaning of rules and regulations, the relationship with other providers, the relationship with the client, the language used to talk about clients, and the meaning of 'advocacy.' The role of the supervisor is the dominant focus of this discussion, but all of the issues noted above will be touched on.

Perceptions of Supervisors

A most surprising discovery was the perception of all six 'best' care managers of the role supervisors play in the quality of care management services. Good supervisors were seen as collaborating rather than as monitoring. Even though these supervisors were often initially described as 'hands off' and as "leaving you alone to do your work," care managers went on to describe a collaborative relationship in which the supervisor was very engaged rather than detached. Each of the six 'best' care managers identified their supervisors as vital to the effectiveness of care management. Each insisted that it was only possible to be an effective care manager when a supervisor displayed certain characteristics and created a facilitating context for their work. Three of the six care managers had had unsupportive supervisors in the past and were able to talk about specific differences between supportive and unsupportive supervisors.

Best CMs' Perceptions of Good Supervisors

- Mentor
- Available
- Involved
- Experienced
- Responsive/Respectful
- Trusting
- Facilitating/Smoothing the way

- Accepting of Mistakes/Forgiving
- Supportive of Risk Taking
- Repairs/Controls Damage
- Sense of Humor

Mentor

When talking about 'good' or supportive supervisors, these care managers often referred to them as mentors. In fact, four referred to past supervisors as the most important mentors in their careers. Mentors were described by these care managers in similar ways. They were teachers/supervisors who taught primarily by example. The best supervisors were described as experienced care managers. This experience allowed them to bring wisdom to discussions about clients and the complexities of care management.

Available

A good supervisor's involvement was described as supportive and facilitating, rather than punitive or intrusive. Such a supervisor was available upon request to participate in problem solving about difficult clients. This was distinguished from supervisors who 'did surveillance,' 'eaves' dropped,' or reviewed documentation to monitor or 'check up' on the care managers, looking for something wrong. Good supervisors allowed care managers to bring problems to them rather than to go looking for them. One care manager commented:

> "He lets us do our job. He treats us as professionals. He figures we have the judgment to know, to ask for guidance. He won't intrude unless you ask him."

Experienced/Involved

Good supervisors often continued to be involved in direct service by either maintaining a small caseload or by remaining 'close' to direct provision of services. It was not necessary for a good supervisor to maintain a case load to stay involved, however. Supervisors could also stay close to the provision of services by direct, ongoing involvement in problem solving with staff about their tough cases. In this latter case, mentor/supervisors were able to come

up with helpful, practical suggestions that revealed an understanding of the issues involved and an appreciation of how difficult and complex these problems could be.

The comments made by good supervisors demonstrated an understanding of what it feels like to be a care manager faced with a difficult decision. This was often done by sharing personal anecdotes about mistakes the supervisor had made as well as telling stories about successes in practice prior to becoming a supervisor.

Feedback from supervisors was considered problematic or intrusive, however, when supervisors openly disagreed with care managers' assessments of the client's best interests. Supportive feedback from supervisors acknowledged the care managers role in defining what was best for the client. This included clear recognition that the care manager were closest to clients and were in the best position to evaluate client needs. 'Personalizing' the plan of care required close, on-going knowledge of the client and his/her personal circumstances and could not be understood by someone who was not involved at that level. No abstracted view or guidelines could supersede the care manager's personal knowledge. One of the managers, referring to the importance of supervisor feedback, said:

> "I think I can do it (care management) because of my boss. He knows because he's been a case worker. He says client contact is most important. He's not one of these guys who says 'Is you paperwork done?"

Responsive/Respectful/Trusting

Good supervisors demonstrated trust in their care managers. A mutual respect and trust between supervisor and care manager was considered essential for effective care management. Descriptions of relationships with good supervisors could be characterized as highly interactive, trusting and engaged.

Facilitating/Smoothing the Way

Another helpful quality of good supervisors was assisting care managers to see the consequences of their actions rather than to make decisions for them. Feedback from supervisors was considered particularly helpful when it assisted the care manager to work the system in order to get what the care manager believed the client needed. A good supervisor

could point out consequences such as a detrimental impact on resources for the caseload as a whole or damage to relationships with important providers. Supportive supervisors were consistently described as able to comment on how service plans and their implementation might affect the larger system of providers and the integrity of the relationship that providers had with the county, with other care managers, or with the agency in general. Referring to provider relations, one supervisor commented to his case manager:

> "If you push that hard, you will probably get what you want this time. Don't forget that there may be a time in the future when you need some help, a service your client is not really entitled to…If you negotiate now…they are more likely to negotiate then."

Another supervisor pointed out the importance of distributing resources carefully:

> "If you advocate for your client in that particular way, there will be fewer resources available for others on the caseload. Is there a way to maintain your commitment to this client while not using up resources that others will need?"

Accepting of Mistakes/Forgiving

Good supervisors were accepting of mistakes and supportive of 'reasonable' risk taking. The emphasis on risk taking and the possibility of making mistakes was fairly striking. This group tended to take risks more than the other groups of care managers. Good supervisors were described as those who would remind care managers about the consequences of what they were pondering, provide some 'reality checking' on just how far over the line a particular action would take them, and remind the care managers to pick these transgressions carefully. This was considered the perfect balance for effective work since it left the care manager to be a bit zealous on behalf of the client, to err on the side of greater advocacy. A good supervisor would provide the safety net that might be required under such circumstances, preventing the care manager from damaging his/her own (or the agency's) credibility in the community.

Supportive of Risk Taking

Good supervisors were supportive of risk taking. However, these 'best' care managers understood that a supervisor would be put in a difficult position if asked to openly support a care manager's decisions or actions that seemed to bend or even flaunt the rules. It was important that care managers who decided to take such an action knew that they could count on their supervisors for support if they were to need it later. One care manager talking about meeting with providers mentioned:

> "They don't think we have bosses because of the way we act. I can't say…sitting at the table negotiating…'Well, I'll get back to you.' You have to be able to negotiate with authority and then back it up."

Another care manager, describing his supervisor's past experience, commented:

> "He has an attitude, he knows because he's been a case worker. He knows if you have to do it, you have to do it. It comes under "Other" in the job description."

The strategy care managers used was to avoid discussing the transgression before it occurred, to avoid putting the supervisor in a difficult place. It was crucial for them to be confident, however, that the supervisor would be supportive later if the care manager got into trouble. For example, if a care manager was too pushy with a provider or used services that the client was not really entitled to, or demanded special treatment for a client, the supervisor would deal directly with the provider who had experienced the problem with the care manager. The good supervisor would smooth things over. In this situation, the supervisor might explain to the provider that the care manager just got carried away and was really well intentioned, just a bit zealous. This could occur even if there was tacit agreement between the supervisor and the care manager about the actions that had been taken.

The tacit agreement was, in fact, not to discuss such transgressions beforehand. This agreement included crossing a line that could only be crossed on rare occasions. These care

managers all knew that such 'line crossing' must be engaged in judiciously. The risk of crossing the line too often was to lose the trust and support of the supervisor.

Engages in Damage Control and Repair

Effective care management was consequently enhanced by a supervisor's willingness to engage in damage control and repair. Examples of this were most often related to relationships with outside providers on contract with a particular county. This type of damage control requires a tremendous amount of trust between the care manager and the supervisor. It means that the supervisor can count on the care manager not to be too flagrant or outrageous, too often, and to take 'reasonable' risks only for 'good' reasons.

The strategy of going too far on occasion is an important one that these care managers kept in their back pockets for just the right time. In these situations care managers assumed that on occasion they can go 'too far' knowing the supervisor would repair any damage without anger or punitive action. As one care manager explained:

> "He wrestles with…he has to maintain good provider relationships and deal with case managers who are stirring things up."

This is part of the tacit agreement between the two. It requires trust, mutual respect and a highly engaged relationship.

Sense of Humor

Four of these care managers also identified a sense of humor as a necessary characteristic of a good supervisor. Humor was crucial when dealing with providers, funding sources and with day-to-day dilemmas faced by care managers. Humor was perceived as a way of acknowledging a difficult situation without succumbing to it.

Less Helpful Supervisors

Care managers who had worked with supervisors they considered difficult or unsupportive described this group as supervisors who: are clearly in charge of watching and passing judgment on what you do; use their own perspectives to interpret (reinterpret) what

you have decided; feel they have experience that has imparted more wisdom to them than yours has to you; go looking for something wrong or check to ‘make sure’ you are doing it right, rather than checking to see where they can be helpful or supportive; try to prevent you from ever making mistakes; seem to have a consistent theme that is used repeatedly (don’t let people get too dependent); do not back you up when you have made a mistake; don’t warn you when they see trouble coming your way (let you learn, the hard way, from your mistakes); and expect careful rule following (rules as ends rather than means).

Characteristics of Less Helpful Supervisor

- Lying in wait
- Possessing better insights than yours
- Being heavy handed
- Engaging in surprise attack practices
- Being (too) cautious
- Seeing their problems as more important than yours
- Having single, consistent interpretations
- Cutting you loose when you need backup
- Making sure you learned important lessons from your mistakes
- Seeing rules as ends rather than means

Characteristics of Best Practice

Each of the six excellent care managers stated that excellent care managers are certain kinds of people; that ‘who you are’ is much more important than ‘what you know’ and that being a great care manager is not about a skill (or skills) that can be taught or learned. However, the descriptions of excellent practice suggest that there is indeed much about excellent practice that can be learned to enhance the quality of care management practices.

Honoring the Spirit of the Rules

In addition to the significance of the context created and maintained by good supervisors, there were clear markers that distinguished excellent practice in care management. These characteristics were not always identified by the care managers

themselves, but instead, were discovered by comparing how these six care managers' descriptions of their work differed from descriptions offered by other care managers.

Each of the care managers in this group stated a respect for the rules and an understanding of their purpose and usefulness. Only one of the six care managers actually referred to herself as a rule breaker. However, each also (spontaneously) described instances in which the spirit of the rule was followed but the letter was not. Respect for following the rules was interpreted by these care managers as following the spirit of the rule rather than precisely adhering to it. Stories of rule bending and rule breaking were actually offered as examples of following the rules.

Unlike many of the care managers in the other groups, honoring the spirit of the rule was repeatedly (but not explicitly) described as sufficient and acceptable. The rules were perceived and used as guides rather than mandates; philosophies rather than prescriptions. These care managers told many stories about how they respected the rules while not following them strictly. The commitment, support and understanding of a supervisor was important in maintaining this approach since it required the supervisor to have a similar view of rules.

Risk Taking

Risk taking was identified by each of the six 'best' care managers as important for both clients and care managers. Clients needed to be allowed the 'dignity of risk' and care managers needed to be supportive of that risk taking. This risk is taken very seriously by these care managers. It is not indiscriminate, but must always be done deliberately with a specific purpose in mind that justifies the risk. Too much risk taking can result in loss of trust by your supervisor, quickly using up favors, negative consequences for your client, and angering the providers that you must continue to work with or rely on. While these care managers all discussed how important it was that supervisors support risk taking, each also acknowledged how possible outcomes had to be considered carefully and in advance. Each in some way said that risks were taken only when something very important to the client was at stake. Each of these care managers also acknowledged the risk involved in angering community providers, especially when there were only a few (or one) in an area who was providing a particular service. Obviously, an assessment of when a risk is justified and worth

the trouble requires an intimate knowledge of the client and what will affect the client's quality of life. This ability is the basis of personalizing care.

Nurture the Personal Side of Relationships

Common to each of the care managers in this group was a recognition of how important it was to maintain positive and respectful relationships with supervisor, colleagues, clients, families of clients, and other providers. These care managers spent a tremendous amount of time and energy nurturing all of these relationships. This was carefully distinguished from abandoning what was important to your client in order to keep everyone else involved in a particular case content. As one care manager pointed out, this latter behavior can be a problem:

> "There's a tendency to make everyone happy and, in the end, I think, the client gets the short end of the stick."

Compared to other care managers, the six 'best' care managers differed significantly on the attention and concern they devoted to relationships. Each of the six had specifically developed strategies to nurture relationships with providers in the community or knew they could rely on their supervisors to do so. Some made efforts to become friendly enough with providers that it was much more difficult for these providers to say "NO" to the care manager when his/her client needed something from that provider. It also helped to know, personally, what particular providers are most interested in or committed to as well as what tends most to upset them. Hence, relating on a personal level not only makes work relationships more enjoyable, but it increases the effectiveness of the work.

The sort of relationships these care managers created with coworkers also facilitated their ability to negotiate and adapt services in a way that could more closely meet a particular client's needs. None of these care managers would back away from a service they believed was important to their clients, even knowing their advocating would anger providers. The supervisor played a crucial role here in repairing the working relationships and being willing to anger providers as a consequence of advocating. This was often related to availability of both formal and informal assistance. One care manager in a county with limited providers

was so well linked with the community that she knew there would always be informal back up available.

Managing Without Formulas

In contrast to other care managers interviewed, the group of 'best' care managers lacked any notion of specific formulas for allocating their time among the clients on their caseload. None of the six care managers used formulas that distributed time, effort or resources in a way that conformed to any abstract sense of fairness. Instead, decisions about how to allocate their time were all framed in terms of what a particular client needed at that time. The language of fairness, in fact, was used by many other care managers, but by none in this group. The concept of fairness or equity was perceived by these excellent care managers as too abstract and too far removed from the client and what the client needed to be responsive to individual needs. When used by care managers in the other two groups, the notion of fairness referred to a way of distributing resources that was guided by a general rule rather than being directly responsive to individual situations. In fact, several care managers in the other two groups discussed a high level of individual responsiveness as inherently 'unfair' since it almost always resulted in unequal distribution of resources.

The strategy used by the best care managers required an intimate understanding of what each client needed at any given time including who needs more resources and who can get along with less. This practice requires a willingness to break rules about mandated visits to clients in certain programs. This strategy also implies the care managers' ability to know when needs and level of needs shift. A consequence of this type of practice was difficulty when deciding how to allocate time and other resources in the absence of helpful formulas and unlimted needs.

In order to assess how to distribute time and other resources among clients in the absence of guiding formulas, care managers consistently reexamined their contacts and worried about how well they were doing this. There was always a level of uncertainty about whether there might be a better way of doing things. This lack of certainty was expressed by one care manager quite clearly:

> "…easier to be an accountant because at the end of the day I could add up my two columns and know that I did a good job, because I would know that it came out the way it was supposed to. In this job I don't know."

Listening and Knowing

Repeatedly, these 'best' care managers talked about the importance of listening to clients and the inability to do their work well if they didn't. Almost all of them told stories about clients who they had not listened to carefully enough and the unfortunate consequences that resulted.

Related to this was the striking distinction between how this group and other care managers talked about their clients. The six care managers whose practices were described as excellent all spontaneously told stories about their clients that revealed an intimate understanding of who the clients were, a familiarity and closeness that revealed itself in a richness of detail and level of sensitivity that was not often seen in other care managers. This story telling was a hallmark of the interviews with the 'best' care managers. The personal engagement was obvious and could be starkly contrasted with the more detached stance of care managers who knew the cases well but did not know the people intimately. This idea is clearly stated by a care manager who described the importance of personalizing care with comments like:

> "I believe we need to consistently tell real stories, put real faces, to all aspects of our decision making."

And

> "…to really see that person's life as close as possible as to how they see their own life."

This level of intimacy and personal investment seemed to be associated with both a greater appreciation of what was most important to clients and a greater willingness to take a

risk to get that. This may, in part, explain the greater emphasis on risk taking seen in the original six care managers.

Summary and Conclusion

The tasks of care management, so often listed in the literature and as part of job descriptions, come to life when they are rewritten using the words and experiences of the care managers interviewed for this study. Based on interviews with the six best care managers, care management tasks can be defined as outlined below.

The Work of Care Management

Assessing Need
Knowing the client well enough to know what is really important, when to advocate, when to take risks or support the client to take a risk, knowing what can be let go without negatively affecting a client's quality of life.

Coordinating Services
Creating services where none exist or appropriate services are not available. Carefully matching clients to selected services. Stepping forward/backward as needed.

Gaining Access
Getting in quickly when you need it by waiting and compromising whenever you can. Nurturing relationships with providers and gate keepers. Bending eligibility rules. Swapping with colleagues.

Reducing Costs
Understanding the costs of your decision to the client, other clients, and yourself. Weighting the risks and benefits for now and the future. Keeping some reserves hidden to allow for emergencies, bartering.

Advocating
Creating the right context. Understanding how and when to call in favors. Having a reserve on which to draw. Knowing how far to go; when it's important to take risks and 'cross the line' and how often to push.

Personalizing Services
Spending enough time with clients to get inside. Understanding what's really important. Appreciating the intimate details that really matter. Never working from a formula. Never using a checklist. Always listening. Putting a face on it.

Monitoring Quality
Creating quality indicators for each client. Getting enough documentation done to stay out of trouble. Keeping in touch. Paying attention to the important details.

Giving Direct Service
All of the above

The most striking and consistent difference between the excellent care managers and the others is the relationship between supervisor and care manager. Excellence seems to be possible when the skills and perspectives of an excellent care manager are working in the right context; one that is created by an excellent supervisor. Neither alone is sufficient. The

characteristics of ‘best’ practice identified by the best care managers all require the support and cooperation of the supervisor and cannot be effectively engaged in without that support.

Perceptions of care management and what constitutes excellence in practice vary in consistent ways between the six ‘best’ care managers and others. The perceptions of the six excellent care managers about their work also differ markedly from those of the regulators without care management experience. Those findings have important implications for designing educational programs to improve care management, for creating contexts that facilitate ‘best’ practice, and for providing effective oversight of care management practice.

While there is some overlap in criteria used, there is also a significant difference/disagreement among these groups in relation to the criteria used to determine excellence.